Welcome

Patient Information

Patient Name ______________________
Last Name

____
First Name *Middle Initial*

Address ______________________

____

City ______________ State ________ Zip __________

E-mail ______________________

Sex ☐ M ☐ F Age ________ Birthdate ______________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorce ☐ Partnered for ______ years

Occupation ______________________

Patient Employer/ School ______________________

Employer/ School Phone ______________________

Spouse's Name ______________________

Spouse's Birthdate ______________________

Spouse's Employer ______________________

Who may I thank for referring you? ______________________

Phone Numbers

Primary Phone Number ______________________

☐ *I grant Weber Physical Therapy permission to leave voice mail at the primary phone number above*

Secondary Phone Number ______________________

Best time to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Phone Number ______________________

Insurance

Who is responsible for account? ______________________

Relationship to Patient/ Self ______________________

Insurance Company ______________________

Group # ______________ ID # ______________

Birth date ______________ SS# ______________

☐ In- Network ☐ Out-Of-Network

Co-Pay ______________________

Deductible ______________________

Amount Applied ______________ *As of* ______________

Co Insurance ______________________

Out of Pocket Max ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

______________________ and assign directly
Name of Insurance Company(ies)

to ***Weber Physical Therapy*** all insurance benefits. If any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. ***Weber Physical Therapy*** may use my health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient/ Parent/ Guardian

____
Printed name of Patient/ Parent/ Guardian

______________ ______________
Date Relationship to Patient

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Insurance Company ______________________

Group # ______________ ID# ______________

By signing here I verify that all the information listed above is accurate. Under any falsification of date or information Weber Physical Therapy has the right to obtain compensation and retributions from the hereby signed person.

Patient Signature ______________________ Date: ______________

Therapist Signature ______________________ Date: ______________